Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
KERRY J YANCY

Respondent Name
DALLAS ISD

MFDR Tracking Number
M4-14-0862-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 15, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "**(F) a position statement of the disputed issue(s) that shall include:**

(i) **a description of the health care for which payment is in dispute,**
DESIGNATED DOCTOR EXAM

(ii) **the requestor's reasoning for why the disputed fees should be paid or refunded,**
CARRIER IS REQUIRED TO PAY DESIGNATED DOCTOR EXAMS

(iii) **how the Labor Code, Division rules and fee guidelines impact the disputed fee issues, and**
THE CURRENT RULES ALLOW REIMBURSEMENT."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The issue is in regards to the reimbursement for procedure code 99456WPW5 for two units. The provider billed a total of three procedures codes for the above date of service: Code 99456W5WP (2 units) for MMI and impairment rating of one compensable area (shoulder) and one-non compensable area (cervical). Code 99456W5MI was billed for multiple certifications (cervical) Code 99456WRE for extent of injury. Per 28 §134.204(i)(j), the reimbursement for procedure code 99456W5WP is for MMI and the impairment rating caused by the compensable injury. Since the cervical area is a disputed condition, as stated on pg 6 of the medical records, it was not appropriate to bill two units for this code.

Therefore, the prior reimbursement of $650.00 for procedure code 66456W5WP is correct and no additional allowance is due. ($350 for MMI and $300.00 for the impairment rating of the compensable area the shoulder)"

Response Submitted by: Argus

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 17, 2013	CPT Code 99456-WP-W5	$150.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1A – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT REIMBURSEMENT PER RULE 134.203/134.204
   - 193W – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY. * PREVIOUS RECOMMENDATION WS IN ACCORDANCE WITH THE WORKERS COMPENSATION STATE FEE SCHEDULE

Issues

1. Are the disputed services performed billed in accordance with 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204 states "(i) The following shall apply to Designated Doctor Examinations. (1) Designated Doctors shall perform examinations in accordance with Labor Code §§408.004, 408.0041 and 408.151 and Division rules, and shall be billed and reimbursed as follows: (j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows: (C) If the examining doctor determines MMI has been reached and an IR evaluation is performed, both the MMI evaluation and the IR evaluation portions of the examination shall be billed and reimbursed in accordance with paragraphs (3) and (4) of this subsection. (3) The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350. (4) The following applies for billing and reimbursement of an IR evaluation. (A) The HCP shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the units column of the billing form. (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas. (i) Musculoskeletal body areas are defined as follows: (I) spine and pelvis; (II) upper extremities and hands; and, (III) lower extremities (including feet). (ii) The MAR for musculoskeletal body areas shall be as follows. (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area; and(-b-) $150 for each additional musculoskeletal body area. (iii) If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier "WP." Reimbursement shall be 100 percent of the total MAR."

   Review of submitted DWC-69 indicates the issues to be addressed by the performing doctor for disputed service July 17, 2013 were maximum medical improvement, impairment rating with two body areas rated using range of motion method and extent of injury.

   Further review of Division notes finds a DWC-32 (Request for Designated Doctor Examination), maximum medical improvement, impairment rating and extent of injury were the following examinations requested to be addressed. Therefore, CPT Code 99456-WP-W5 is supported. The total reimbursement for the disputed service in dispute is $800.00.
2. The respondent issued payment in the amount of $650.00 for CPT Code 99456-WP-W5. Based upon the documentation submitted, additional reimbursement is recommended in the amount of $150.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		7/25/2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.